

1

7169

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07157

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Armon</u> First <u>R.</u> Middle <u>Brown</u> Last				4. DATE OF DEATH <u>June</u> Month <u>14</u> Day <u>1961</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 29, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during/most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Thomas Brown</u>				14. MOTHER'S MAIDEN NAME <u>Rachael Anne Ringold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Ms. Coretta Jones - Grasonville, Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Sev. Yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>61</u> , to <u>June</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1961</u> , and that death occurred at <u>4:30</u> P.M. from the causes on and on the date stated above.							
22a. SIGNATURE <u>Irvin G. Hoyt</u>				22b. DATE SIGNED <u>6/15/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>				22d. ADDRESS <u>Queenstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-18-61</u>		<u>Grasonville Cem.</u>		<u>Grasonville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. R. Hill</u>				25a. REC'D BY REGISTRAR <u>DATE 23 '61</u>			
ADDRESS <u>Easton, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

02151

CERTIFICATE OF DEATH

102



*[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]*

1  
FOR STATE  
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

7170  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07153

1. PLACE OF DEATH e. COUNTY <b>QUEEN ANNE'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE'S</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CENTREVILLE</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL CENTREVILLE</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Thomas Brown</b>				4. DATE OF DEATH Month Day Year <b>JUNE 4 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1918</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GRADER DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Road Construction</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES S. BROWN</b>				14. MOTHER'S MAIDEN NAME <b>FRANCES JOHNSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-12-0286</b>		17. INFORMANT Address <b>Mrs. FRANCES BROWN, RURAL CENTREVILLE Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Cornary Insufficiency</b> (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>2 years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>C. R. Layton</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>C. R. Layton</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>6-5-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/8/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CARMICHAEL CEMETERY</b>		22d. LOCATION (City, town, or country) (State) <b>RURAL QUEENSTOWN, MARYLAND.</b>	
23. FUNERAL DIRECTOR ADDRESS <b>James H. Baiting, Jr. of Baiting Bros., Centreville, Md.</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	
				DATE <b>JUN 8 '61</b>			

FOR SALE  
17A

Charles Brown's  
Central Station

Charles Brown's  
Central Station

Charles Thomas Brown

White Negro  
Wife & Child

A211

Charles Thomas Brown  
Central Station

Charles Thomas Brown  
Central Station

Charles Thomas Brown  
Central Station

Charles Thomas Brown  
Central Station

Charles Thomas Brown  
Central Station

## CERTIFICATE OF DEATH

Reg. Dist. No.

07160

7171

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pondtown</b>				c. LENGTH OF STAY IN 1b <b>Pondtown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>X</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Hines</b> Last <b>Hines</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown 1894</b>		9. AGE (In years last birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Maria Hines</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.1</b>		INFORMANT <b>Ella Hines</b> Address <b>Sudlersville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>many years</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis Deformans</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no injury</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11-30, 1961</b> to <b>6/16/1961</b> , that I last saw the deceased alive on <b>June 11</b> , 19 <b>61</b> , and that death occurred at <b>1:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/16/61</b>							
ACTUAL SIGNATURE <b>H. H. Hamilton</b>				M.D. <b>William G. Hines</b>			
PHYSICIAN'S NAME (Type) <b>H. H. HAMILTON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 17, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pondtown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 19 1961</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOWARD ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

071

1911

Given Name *John* Surname *Smith* Sex *M* Age *45* Date of Birth *Jan 15 1866*

Place of Birth *London, England* Cause of Death *Heart Disease*

Signature of Physician *John Doe* Signature of Registrar *John Doe*

Witnesses *John Doe* *John Doe* Date of Death *Jan 15 1911*

Place of Death *London, England* Buried at *St. Paul's Church*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

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Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

Signature of Registrar *John Doe* Signature of Registrar *John Doe*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one day is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G290 7/7/61 iwk

Reg. Dist. No. 07161

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wye Mills</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>503 N. Wolfe</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marilyn</u> Middle <u>Nelson</u> Last <u>Kriewald</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1934</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physical Therapist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Litchfield, Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George E. Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Irene M. Schultz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>472-36-4263</u>	
17. INFORMANT <u>Haggaland Funeral Home</u>		Address <u>Litchfield, Minnesota</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Brain damage</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>crushing injury to skull</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushed chest. Multiple fractures rt. arm. Fractures lt. leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10:30</u> 6-29-61 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Wye Mills</u> (County) <u>J. A. Md.</u> (State) <u>J. A. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>6-30-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ripley Cemetery</u>		22d. LOCATION (City, town, or county) <u>Litchfield, Minnesota</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Nelson</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	



TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7173

07162

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ingleside</b>				c. LENGTH OF STAY IN TB <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Rochester</b> Last <b></b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 13, 1872</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>		11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abraham Rochester</b>				14. MOTHER'S MAIDEN NAME <b>Mary Tilghman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Conrad Rochester Church Hill, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Phlebotomy</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Anemia, secondary</b>						INTERVAL BETWEEN ONSET AND DEATH <b>96 hours</b> <b>10 years</b> <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b></b> Day <b></b> Year <b>19</b> Hour <b></b> a. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1960</b> to <b>June 10 1961</b> , that (I) (we) last saw the deceased alive on <b>6-3-1961</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John R. Smith, Jr.</b>				22b. DATE SIGNED <b>June 11, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>John R. Smith, Jr.</b>	
22d. ADDRESS <b>Centreville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rich Neck Hall Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>nr. Church Hill (Q.A. Co. Md.)</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bennett V. Vandy</b>				25. REC'D BY REGISTRAR DATE <b>JUN 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Pearson</b>	

*Bennett V. Vandy*

**Chestertown, Md.**

07110

CELESTINE DE L'AMOUR

07110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO REGISTER: This certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7174

## CERTIFICATE OF DEATH

Reg. Dist. No.

07163

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Stevensville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Stevensville - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hannah Christina Spence</u>		4. DATE OF DEATH Month Day Year <u>June 28 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1890</u> 71 yrs.
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Conley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Clinton Spence</u> Address <u>Stevensville, Md.</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u> <u>? yrs</u> <u>? yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>June</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>6/29/61</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cen.</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Robert Barton, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 3 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

CERTIFICATE OF DEATH

07183

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Usual residence: <u>123 Main St., Baltimore, Md.</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Date of death: <u>Dec 10, 1945</u></p>	
<p>9. Time of death: <u>10:00 AM</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>12. Signature of registrar: <u>John Doe</u></p>	
<p>13. Signature of informant: <u>John Doe</u></p>		<p>14. Signature of witness: <u>John Doe</u></p>	

